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No. 01-1423

IN THE
Supreme Court of the United States

SPENCER WADDELL,

Petitioner,

v.

VALLEY FORGE DENTAL ASSOCIATES, INC.,

Respondent.

On Petition for a Writ of Certiorari to the United States Court of Appeals for the Eleventh Circuit

~~**MOTION FOR LEAVE TO FILE BRIEF AND**~~ **BRIEF OF THE AMERICAN DENTAL ASSOCIATION AS AMICUS CURIAE IN SUPPORT OF PETITIONER**

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MOTION OF THE AMERICAN DENTAL ASSOCIATION FOR LEAVE TO FILE BRIEF AS AMICUS CURIAE

The American Dental Association (the "Association") hereby moves this Court pursuant to Rule 37.2(b) of the Rules of the Supreme Court for leave to file a brief as *amicus curiae* in support of the Petition for a Writ of Certiorari to the United States Court of Appeals for the Eleventh Circuit. The Association has received consent from petitioner, but respondent has refused to consent.

The Association, an Illinois not-for-profit corporation founded in 1859, is the leading dental association in the United States with over 140,000 member dentists representing more than 70% of this Nation's active licensed dentists. The stated object of the Association, as set forth in its Constitution, is to "encourage the improvement of the health of the public and to promote the art and science of dentistry." The Association has a vital interest in matters that affect the oral health of the public, and a long record of educating dentists and the public about the safety of the dental office, the efficacy of infection control procedures (commonly referred to as "universal precautions"), and HIV-disease as it relates to dental treatments.

The Association seeks to submit its Brief *Amicus Curiae* in order to present to the Court information about its science based policy that the treatment of patients by a dental practitioner with HIV-disease does not pose a significant risk to patients. The Association believes this information will aid the Court in its review of the Court of Appeals decision affirming summary judgment against the petitioner Spencer Waddell.

It is also vitally important for the Court to provide clear guidance to healthcare providers and patients regarding their respective rights and obligations under the Americans with Disabilities Act, 42 U.S.C. § 12101, *et seq.* (the "Act"). Casting the provision of dental hygiene as a "significant risk" that constitutes a "direct threat," as the Eleventh Circuit did in this case, is inconsistent with this Court's decision in *Bragdon v. Abbott*, 524 U.S. 624 (1998), and conflicts with the decisions of other circuits. Reaffirmation of this Court's holdings in *Bragdon* and resolution of the circuit split on "direct threat" and the burden of proof are essential to facilitate the Association's continuing efforts to educate its

members on their responsibilities under the Act. Moreover, if left uncorrected, the Eleventh Circuit's decision threatens to undermine the public's confidence in the safety of dental treatment and the Nation's healthcare system.

The Association respectfully requests that it be granted leave to file its brief as *amicus curiae* to highlight the science that underlies its policies and the importance of this case to the country's public health.

Respectfully submitted,

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INTEREST OF THE AMICUS

The AMERICAN DENTAL ASSOCIATION (the "Association"), an Illinois not-for-profit corporation founded in 1859, is the leading dental association in the United States with over 140,000 member dentists, representing approximately 70% of this Nation's active licensed dentists.[1] The stated object of the Association, as set forth in its Constitution, is to "encourage the improvement of the health of the public and to promote the art and science of dentistry." The Association has a vital interest in matters that affect the oral health of the public, and a long record of educating dentists and the public about HIV/AIDS and the safety of the dental office.

As we did in the filing of a brief in support of a petition for *certiorari* in the first ever case involving HIV to come before this Court, *Bragdon v. Abbott*, 524 U.S. 624 (1998), the Association again asks this Court to clarify what remains to many dentists and other healthcare providers an ambiguous federal law, the Americans with Disabilities Act, 42 U.S.C. § 12101, *et seq.* (the "Act"). We urge this Court to address two key questions pertaining to the Act's definition of "direct threat," so we can give appropriate guidance to our members, who can in turn use this information when treating the American public.

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[1] Pursuant to Rule 37.6 of the Rules of this Court, *amicus* states that no counsel for a party authored this brief in whole or in part, and that no person or entity other than *amicus* and its counsel made any monetary contribution to the preparation or submission of this brief.

We are concerned that absent clarification about "direct threat," lower courts will continue to send mixed messages to health care professionals and the public about their rights and responsibilities under the Act. This will contribute to unwarranted public concerns about the safety of receiving healthcare in this country, including but not limited to care received in the dental office. To protect against these outcomes, it is critical that this Court reaffirm its position that a party raising the "direct threat" defense must do so based on medical evidence of risk, as opposed to theory.

SUMMARY OF ARGUMENT

1. This Court needs to reaffirm its previously expressed views regarding the "direct threat" defense allowed under the Americans with Disabilities Act, 42 U.S.C. § 12101, *et seq.* (the "Act"). Doing so is necessary in order to provide clear guidance to healthcare practitioners and patients alike about their rights and responsibilities under the Act, and to resolve a conflict among the circuits that has the potential for sending mixed messages to the public about the safety of the dental office and the efficacy of universal precautions. This can be best done by reinforcing that "direct threat" is established only by scientific evidence of significant risk, as opposed to theoretical speculation, and that it is the burden of the party asserting the defense to prove such risk.

As set forth in the Association's policies regarding HIV-disease and infection control, "[c]urrent and generally accepted epidemiological information supports the conclusions that (i) there is no significant risk of contracting bloodborne diseases through the provision of dental treatment when appropriate infection control procedures are followed," and (ii) the "practice of universal precautions is an effective means of reducing blood contacts that can result

in bloodborne pathogen transmission, minimizing even further the already low risk of disease transmission in the dental office." American Dental Association, *Policy Statement on Bloodborne Pathogens, Infection Control and the Practice of Dentistry* 1, 2 (1999). The Association's science based policies establish that a dental practitioner with HIV-disease does not present a significant risk to patients when appropriate infection control procedures are followed.[2]

In *Bragdon v. Abbott*, 524 U.S. 624, 651-52 (1998), this Court invited the First Circuit on remand to evaluate the scientific basis for the Association's policy. The First Circuit determined that "the origins of the [Association's] Policy satisfy any doubts regarding its scientific foundation." *Abbott v. Bragdon*, 163 F.3d 87, 90 (1st. Cir. 1998), *cert. denied* 526 U.S. 1131 (1998). Indeed, not only are the Association's policies scientifically based, it is that very science that helps the Association to naturally participate with this Court in the educative aspect of the Act, by teaching its members about the scientific basis for what is required of them under the law. This Court's clarification in *Bragdon*, both with respect to "disability" and "direct threat" helped immeasurably in the Association's efforts to educate members about their rights and responsibilities under the Act.

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[2] The Association has developed numerous policies with respect to AIDS, HIV and Infection Control since the onset of HIV-disease in this country. In 1999, most of those policies were coalesced into an umbrella *Policy Statement on Bloodborne Pathogens, Infection Control and the Practice of Dentistry*. Relevant prior policies include the Association's *Policy on HIV-Infected Dentists* (1991:592; 1997:700) and *Position on AIDS, HIV Infection and the Practice of Dentistry* (1998:457; 1991:591; 1997:701), the principal portions of which were in effect at the time of appellant's employment by appellee.

2. The conflict among the circuits identified in the instant Petition for *Certiorari* have called into question the fundamental lessons that dentists and other healthcare providers should have learned under *Bragdon*. It is important that those messages be restated by the Court and the circuit conflict be resolved in a way that clarifies that "direct threat" can be established only by scientific evidence and that the burden rests with the party asserting the defense.

Any other result risks sending mixed messages to patients and providers, both infected and uninfected alike, regarding their rights and responsibilities under the Act. Moreover, it would risk undermining the core public health message about the safety of providing dental and other healthcare in this country. This last point cannot be underestimated, given the potential for a public health crisis that could arise if healthcare providers returned to discriminating against people with HIV disease and/or the public avoids treatment upon reading headlines suggesting that federal courts have determined that the threat of HIV transmission in healthcare settings is *significant* as a matter of law.

REASONS FOR GRANTING THE PETITION

In *Bragdon v. Abbott*, 524 U.S. 624 (1998), the Court provided clear and specific guidance regarding the questions of "disability" and "direct threat." Although the Court did not determine whether there existed a "direct threat" in that case, the Court provided a veritable road map for any practitioner considering the "direct threat" defense in the context of HIV litigation. On remand in *Bragdon*, the First Circuit ruled -- consistent with Association policies about HIV, infection control and universal precautions -- that the provision of dental care in that case did not pose a direct

threat. *Abbott v. Bragdon,* 163 F.3d 87, 90 (1st Cir. 1998), *cert. denied* 526 U.S. 1131 (1999).

Based on the Court's opinion in *Bragdon*, all health practitioners should have been clear about the importance of significant risk and risk assessment in making a "direct threat" determination:

> [B]ecause few, if any, activities in life are risk free, *Arline* and the ADA do not ask whether a risk exists, but whether it is significant. *Arline, supra,* at 287, and n. 16; 42 U.S.C. § 12182 (b)(3).
>
> The existence, or nonexistence, of a significant risk must be determined from the standpoint of the person who refuses the treatment or accommodation, and the risk assessment must be based on medical or other objective evidence.

524 U.S. at 649.

Furthermore, healthcare practitioners were on notice that the burden falls on the party relying on the "direct threat" defense to present objective evidence creating a triable issue of fact in order to survive a motion for summary judgment on the question of risk. *Id.* at 649-50; 664 (Rehnquist, C. J., dissenting). The Court specifically instructed the First Circuit on remand regarding the quality of evidence that a doctor asserting a "direct threat" defense would need; e.g. significant risk assessment "based on medical or other objective evidence;" the duty to assess risk "based on the objective, scientific information available to him and others in his profession;" according "special weight and authority" to "the views of public health authorities." *Id.* at 649-50.

I. THIS COURT SHOULD REAFFIRM THAT, UNDER THE AMERICANS WITH DISABILITIES ACT, A "DIRECT THREAT" MUST BE BASED ON MEDICAL OR OTHER OBJECTIVE EVIDENCE OF *SIGNIFICANT* RISK, AS OPPOSED TO THEORETICAL RISK.

Notwithstanding the clarity of this Court's opinion in *Bragdon*, the Eleventh Circuit below, and other circuits applying the "direct threat" defense, have raised serious questions about what evidence is sufficient to establish this defense. The thrust of these decisions is that, because HIV inevitably leads to death, the risk is one can that can be deemed to be "significant" even if there is no evidence to support any actual risk and the party asserting the defense acknowledges that the risk of transmission is theoretical. Essentially, this amounts to the abandonment of one of the four key inquiries of the "direct threat" analysis established by this Court in *School Bd. Of Nassau Cty. v. Arline*, 480 U.S. 273, 288 (1987), and reinforced implicitly (based upon the codification of the *Arline* approach under the Act) in *Bragdon*, 524 U.S. at 649.

The one distinct feature of the post-*Bragdon* decisions is that they have typically involved the risk of infection of the patient by a healthcare provider. This distinction makes no legal difference. Under the Act, the same "direct threat" definition applies. Indeed, if anything, science cited by every court that has squarely addressed the issue makes clear that the infinitesimal risk of transmission from infected patient to provider is greater than from infected provider to patient – the circumstances presented in this case.

The line of cases suggesting that health care workers with HIV, like Spencer Waddell, can pose a "direct threat" – usually based on theoretical risk and/or fears associated with the nature of the job -- is at odds with this Court's decision in *Bragdon* and *Arline*. These post-*Bragdon* decisions set the stage for inconsistent interpretations of the "direct threat" defense by providers and patients alike. In so doing, they also run the risk of sending at best confusing messages from the federal courts to the public about the safety of receiving healthcare.

As noted in the Petition for *Certiorari* in the instant case, "[t]he *Bragdon* standard, if applied to the undisputed facts of this case, undoubtedly would have produced a different result," than reached by the Eleventh Circuit. (Petition at 17.) In *Arline*, *Bragdon* and countless other cases, this Court and others have insisted on assessment of risk knowing full well that the risk was greater than zero. There indeed would have been no need to remand *Bragdon* had zero risk been the true measure of a "direct threat."

In addition to saddling plaintiffs "with the virtually impossible burden of proving that something that never has happened won't occur in the future" (Petition at 18), the erosion of this Court's line of authority from *Arline* to *Bragdon* has potentially far-reaching effects on the provision of healthcare in this country. Under *Arline* and *Bragdon*, it is clear to every healthcare worker that refusal to treat someone with HIV disease solely by virtue of their HIV status is unlawful. Moreover, every such practitioner should know that he or she has the burden of establishing "direct threat" by appropriate evidence rather than speculation.

By allowing theory rather than fact to prevail, the Eleventh Circuit's decision raises serious public policy concerns. Healthcare providers may now have a basis to argue, as others before have done, that there are reasonable grounds to refuse treatment of patients with HIV and other infectious diseases when the risk of doing so is death -- even if they have insufficient medical evidence to support the risk of transmission. Court decisions might suggest that the risk of transmission of HIV in healthcare settings is significant enough to allow HIV discrimination. That message by itself, in the face billions of medical and dental procedures having been safely performed since the inception of the HIV pandemic with virtually no known cases of transmission, has the potential to be injurious to healthcare providers and the patients they serve.

The clear and correct message is the one already sent by this Court: that unless and until there is adequate scientific evidence to support the existence of a significant risk, a "direct threat" defense must fail, even if the threat is with respect to a fatal disease such as HIV. Only by standing behind its line of authority that leads to this result, can this Court maintain the accuracy of the message to the American public about the safety of receiving healthcare.

II. THIS COURT SHOULD RESOLVE SPLITS IN THE CIRCUITS REGARDING TWO KEY ASPECTS OF THE "DIRECT THREAT" DEFENSE, SIGNIFICANT RISK AND BURDEN OF PROOF.

The Americans with Disabilities Act was intended by Congress, *inter alia*, to set minimum federal rights for people with disabilities and responsibilities for those providing services to them. While certainly more stringent state laws

remain in effect, the Act plainly contemplated the federal floor that could be relied upon nationwide.

As set forth in the Petition, the circuits are split on at least two significant issues regarding the "direct threat" defense in the context of HIV, significant risk and burden of proof. First, some circuits are allowing the "direct threat" defense to be pursued based on speculation and/or theoretical arguments at best. Second, some circuits are holding that the burden of proof in "direct threat" cases rest with plaintiffs alleging discrimination, who not only have to prove that they were discriminated against but also that there was no "direct threat." The Eleventh Circuit decision below suffers from both of these errors. As a result, healthcare providers and patients in that circuit arguably have different rights and responsibilities than those in other circuits that adhere more closely to the standard articulated by this Court.

A. Even In The Case Of HIV, "Direct Threat" Must Be Established By Evidence Of Significant Risk, As Opposed To Theoretical Speculation.

For there to be a uniform federal floor regarding the "direct threat" defense, this Court should resolve the conflict among the circuits by reinforcing that "direct threat" requires factual scientific support. A dental hygienist, dentist, physician or any other healthcare worker with HIV disease should have no greater or lesser rights under the Act solely by virtue of where he or she practices. In contrast neither should the federal civil rights of HIV patients receiving healthcare in this country fluctuate depending on where they seek care. In each case, both practitioner and patient are entitled to a clear understanding of what type of proof must be established to support a defense of "direct threat."

The conflict among the circuits on the "direct threat" issue greatly impedes the Association's efforts to educate our members on the law and facilitate their compliance. Before this Court's decision in *Bragdon*, some dentists raised questions whether HIV was a disease and not a disability, and whether they could refuse treatment if they believed there to be a "direct threat" of transmission to them. After *Bragdon,* it was clear that for purposes of the Act, HIV infection is usually both a disease and disability, and that healthcare providers have a significant responsibility with respect to building a "direct threat" defense based on sound science.

With the current circuit split about "direct threat," the waters are muddy once again. Now that some of the circuits have chipped away at what seemed to be a clear rule, questions are arising routinely regarding application of the Act to day-to-day dental practice. Many dentists are openly questioning whether the *Waddell* decision below has set a new standard for "direct threat." Moreover, in trying to educate dentists about how to stay within the bounds of the law, the Association is in an unenviable position. The conflict among the circuits makes it appear that the requirements of the Act depend upon where a dentist practices. The Association believes that the same scenario is playing out in other healthcare professions including medicine.

The issue does not stop with the healthcare provider side of the equation. Do individuals with HIV disease have a right to expect equal access to treatment absent a scientifically supported "direct threat" defense? Are the rights of patients with HIV disease determined by where he or she seeks treatment? Can the public rest assured that it is safe to receive healthcare in this country, or will negative

headlines questioning the safety of dental and other healthcare offices raise undue concern about HIV transmission -- perhaps particularly in parts of the country that invoke broad, speculative, *Waddell*-like versions of "direct threat?"

B. The Burden Of Proving "Direct Threat" Falls On The Party Asserting The Defense.

The conflict among the circuits regarding the burden of proof raises similar issues. Clearly, after this Court's decision in *Bragdon*, dentists and other healthcare providers reasonably believed that they had a duty to establish "direct threat" should they elect to raise the defense. However, decisions like *Waddell* below cast doubt on the burden issue. Not only might a dentist no longer have a burden to establish "direct threat;" under *Waddell*, a lay person going to her dentist for routine care, would have to produce scientific evidence regarding the safety of the care. The logic of placing plaintiffs in such a situation is difficult enough to understand. After all, they are neither claiming "direct threat" nor likely positioned, based on their experience, to make an assessment regarding the existence of "direct threat." Stranger still is any notion that a plaintiff in an HIV discrimination case would bear the burden of proving a negative, i.e., the absence of "direct threat." How this can be done, especially if "direct threat" can be established based on theory and speculation, remains a mystery.

The effect of the circuit split regarding the burden of proof could, on its own, make it difficult if not impossible for patients with HIV to effectively seek and secure healthcare in this country, depending on where they seek care. It is important that this Court address the conflict

among the circuits by reinforcing that the party relying on the "direct threat" defense has the burden of proof.

CONCLUSION

There have been two cases involving HIV discrimination in dentistry for which petitions for *certiorari* have been brought so that this Court could address critical issues under the Americans with Disabilities Act. As in *Bragdon*, the American Dental Association again urges this Court to grant the petition in order to provide clear guidance to healthcare practitioners and patients alike about their rights and responsibilities under the Act, and to resolve circuit conflicts that have the potential for sending mixed messages to the public about the safety of the dental office and the efficacy of universal precautions.

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